

**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH**

**JUVENILE JUSTICE TRANSITION AFTERCARE SERVICES (JJTAS)  
TREATMENT, REFERRAL AND AUTHORIZATION FORM**

Email completed form to: [jjtas@dmh.lacounty.gov](mailto:jjtas@dmh.lacounty.gov)

*Referral to be completed by DMH staff only – 45 days prior to Transition MDT. Referrals only accepted via email above.*

Referral Source			
Name:	Title:	Phone:	Email:
Client Information			
Client Name:			DOB: <input type="text"/>
Race/Ethnicity: <input type="text"/>	Preferred Language: <input type="text"/>		
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number: <input type="text"/>		
Insurance (if known): <input type="text"/>	<input type="checkbox"/> Medi-Cal <input type="checkbox"/> Health Families <input type="checkbox"/> Private <input type="checkbox"/> None <input type="checkbox"/> Other:		
<b>Post-Camp Placement:</b>			
Home Address: <input type="text"/>	City: <input type="text"/>	Zip Code: <input type="text"/>	Phone: <input type="text"/>
Contact Person: <input type="text"/>	Telephone Number: <input type="text"/>		
Relationship to Client: <input type="text"/>			
Client is Emancipated Minor: <input type="checkbox"/> No <input type="checkbox"/> Yes      Date of Emancipation: <input type="text"/>			
Name of Camp: <input type="text"/>	Camp Admission Date: <input type="text"/>		
Transitional MDT Date: <input type="text"/>	Projected Release Date: <input type="text"/>	Early Release Date: <input type="text"/>	
DMH Camp Clinician: <input type="text"/>		Phone: <input type="text"/>	Email: <input type="text"/>
Camp DPO: <input type="text"/>		Phone: <input type="text"/>	Email: <input type="text"/>
Field DPO: <input type="text"/>		Phone: <input type="text"/>	Email: <input type="text"/>
Other Agency Involvement			
<input type="checkbox"/> DCFS	Contact Name: <input type="text"/>	Phone: <input type="text"/>	Email: <input type="text"/>
<input type="checkbox"/> Other: <input type="text"/>	Contact Name: <input type="text"/>	Phone: <input type="text"/>	Email: <input type="text"/>
<input type="checkbox"/> Other: <input type="text"/>	Contact Name: <input type="text"/>	Phone: <input type="text"/>	Email: <input type="text"/>
<input type="checkbox"/> Other: <input type="text"/>	Contact Name: <input type="text"/>	Phone: <input type="text"/>	Email: <input type="text"/>
<small>This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.</small>			

Client Name: \_\_\_\_\_

DMH IS#: \_\_\_\_\_

PDJ#: \_\_\_\_\_

### Clinical Issues/Treatment Needs

Please check any that apply and provide details where space is provided:

- |  |  |
|--|--|
| <input type="checkbox"/> Depression  | <input type="checkbox"/> Medical (i.e., medication needs, mental health.):<br>_____<br>_____   |
| <input type="checkbox"/> Violence (i.e. home, gang, domestic violence, etc.)   |  |
| <input type="checkbox"/> Substance use   | <input type="checkbox"/> Brief Overall Clinical Impression (i.e. symptoms, behaviors, strengths and impairments):<br>_____<br>_____<br>_____ |
| <input type="checkbox"/> Child Welfare involvement (past or present)           |  |
| <input type="checkbox"/> Family conflict                                       |  |
| <input type="checkbox"/> Limited interpersonal, social and coping skills       |  |
| <input type="checkbox"/> Impulsiveness   |  |
| <input type="checkbox"/> Trauma (i.e., experienced, a threat, witnessed, etc.) | <u>M.H. and/or Substance Abuse Referrals Made</u> <u>Date Sent</u><br>_____<br>_____<br>_____  |
| <input type="checkbox"/> Anxiety   |  |

#### Recommend:

- ☐ Family Functional Therapy (Family Therapy)
- ☐ Seeking Safety (Group Therapy)
- ☐ Aggression Replacement Therapy (Group Therapy)

#### Court Mandated Treatment

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date Received:

Received  
By:

Supervisor  
Assigned

Date:

Clinician Assigned:

Date:

Initial Screening Date:

Location of Screening:

#### Screening has been completed with the following recommendation:

- ☐ Client accepts JJTAS services
- ☐ Client declines JJTAS services
- ☐ Client accepts services; has been linked to the following agencies:

- |                                     |                           |
|-------------------------------------|---------------------------|
| 1. Name of Agency: _____            | Reason for linkage: _____ |
| Contact Person: _____               | Title and Phone No: _____ |
| Date of 1 <sup>st</sup> appt: _____ | Memo: _____               |
| 2. Name of Agency: _____            | Reason for linkage: _____ |
| Contact Person: _____               | Title and Phone No: _____ |
| Date of 1 <sup>st</sup> appt: _____ | Memo: _____               |
| 3. Name of Agency: _____            | Reason for linkage: _____ |
| Contact Person: _____               | Title and Phone No: _____ |
| Date of 1 <sup>st</sup> appt: _____ | Memo: _____               |

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